



## Medical Services • General Medicine

### July 2007 • Bulletin 397

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### Providers Must Use New Claim Forms

Medi-Cal implemented the use of the *CMS-1500* claim form on June 25, 2007. Providers who previously submitted claims on the *HCFA 1500* must bill on the new *CMS-1500* claim form immediately. Providers not using the new *CMS-1500* should be in the process of transitioning. Failure to use the new form for claims submitted after June 25, 2007 may result in rejection of the provider's claim.

Also, Medi-Cal will not accept *CMS-1500* forms with bar codes. Some providers' systems are automatically printing bar codes on the form, which interferes with the claim adjudication process. Providers who have *CMS-1500* claim forms with bar codes should contact their software vendor to have this function removed.

Submission instructions for *Claims Inquiry Forms* (CIFs) and *Appeal Forms* require a copy of the corrected original claim form be attached. Old *HCFA 1500* claim forms will only be accepted for this reason.

### 2007 CPT-4/HCPCS Codes Reminder

Effective August 1, 2007, Medi-Cal will adopt the 2007 CPT-4 and HCPCS Level II codes. Claims billed for dates of service on or after August 1, 2007 must use the appropriate 2007 codes.

Codes to be added, modified or deleted were listed in the May 2007 *Medi-Cal Update*. Policy for new benefits was announced in the June 2007 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.

### Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) were redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCF).

*This information is reflected on manual replacement pages tar field 1 thru 11 (Part 2).*

### Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that will impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

### Processing Change Schedule

Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

<b>May 2007</b> Sacramento Medi-Cal Field Office	<b>August 2007</b> Fresno Medi-Cal Field Office
<b>June 2007</b> Northern Pharmacy Section (Stockton) Southern Pharmacy Section (L.A.)	San Bernardino Medi-Cal Field Office San Diego Medi-Cal Field Office San Francisco Medi-Cal Field Office
<b>July 2007</b> L.A. Medi-Cal Field Office In-Home Operations South	<b>September 2007</b> TAR Administrative Remedy Section In-Home Operations North

### Incomplete TARs

CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections. Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.

Please see **Processing Changes**, page 3

**Processing Changes** (*continued*)

- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

**Adjudication Response**

CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

**Attachments**

On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

**SSN on TARs**

In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

**National Provider Identifier (NPI) Number**

Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

*Please see Processing Changes, page 4*

## Processing Changes (continued)

State of California - Health and Human Services Agency  
Department of Health Services

**CONFIDENTIAL**

ARNOLD SCHWARZENEGGER, Governor

Medi-Cal Operations Division

**ADJUDICATION RESPONSE**

Provider Number: HSCXXXXXX  
XXX CONTRACT HOSP #2  
3215 PROSPECT PARK DR  
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101  
Date of Action: 06/27/2006  
Regarding: Jane Doe  
TAR Control Number: 9876543210



This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.L.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
<b>Reason(s):</b>		GEN: Modified, refer to comments							
<b>Comment(s):</b>		Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
<b>Reason(s):</b>		GEN: Denied, refer to comments							
<b>Comment(s):</b>		Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
<b>Reason(s):</b>		GEN: Deferred, refer to comments							
<b>Comment(s):</b>		Comments from Field Office Consultant 4							

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

**TAR Requirement, Code Conversion for Botulinum Toxin Type A and B Injections**

Effective for dates of service on or after August 1, 2007, botulinum toxin A (Botox®) will convert from local HCPCS code X7040 (10 units) to national HCPCS code J0585 (per 1 unit). Botulinum toxin B (Myobloc®) will convert from local HCPCS code X7042 (2,500 units) to national HCPCS code J0587 (100 units).

Botulinum toxin A and B are neuromuscular blocking agents used to treat various muscle disorders, and require a *Treatment Authorization Request* (TAR) for reimbursement. The TAR must have documentation justifying medical necessity including specific details regarding treatment, dosage and diagnosis.

Botulinum toxin A (Botox®) dosages are recommended up to 600 units in adults and 400 units in children. Botulinum toxin B (Myobloc®) is used in doses up to 25,000 units. However, higher dosages may be approved based on submitted TAR documentation supporting the medical necessity of the dosage used.

Please see **Botulinum**, page 5

**Botulinum** (*continued*)

If surgical CPT-4 codes are billed, providers should use modifier AG for the primary surgeon, and modifier ZM or ZN for the use of supplies or other drugs. When recipients require electromyography (EMG), endoscopy or anesthesia or sedation when receiving botulinum toxin A or B, those procedures may be reimbursed if billed on the same date of service as the drugs and accompanied by an approved TAR for J0585 and J0587. If two or more sites are injected on the same date of service, providers will bill for the total amount of botulinum toxin units injected.

Examples of conditions and diagnoses that result in muscle spasm that may benefit from treatment with botulinum toxin A or B are as follows:

- Cerebral palsy
- Multiple sclerosis
- Spinal cord injuries
- Cerebrovascular accident
- Spastic hemiplegia
- Blepharospasm
- Strabismus
- Torticollis
- Hemifacial spasm
- Spasmodic dysphonia
- Achalasia and cardiospasm \*

\* Achalasia and cardiospasm treatment with botulinum toxin A or B should be used only if the patient has failed conventional therapy, is at high risk of complications from pneumatic dilatation or surgical myotomy, or if previous procedures have failed or caused a perforation.

- Hyperhidrosis
- Frey's syndrome
- Detrusor hyperreflexia
- Detrusor sphincter dyssynergia
- Anal sphincter spasm
- Anal fissure

Non-medically necessary uses of botulinum toxin such as treatment of headaches, pain syndromes or cosmetic purposes (for example, facial wrinkles) are not reimbursable. In addition, claims for treatments that will not improve function, seem to be investigational, or are considered unsafe and ineffective will be denied.

Botulinum toxin A and B requests for children under 21 years of age require prior authorization by the California Children's Services (CCS) program.

*This information is reflected on manual replacement pages inject 22 and 23 (Part 2) and inject list 3 (Part 2).*

### Diagnosis Restrictions for Gonadotropin Follicle Stimulating and Luteinizing Hormones

Effective for dates of service on or after August 1, 2007, CPT-4 codes 83001 (gonadotropin; follicle stimulating hormone [FSH]) and 83002 (...luteinizing hormone [LH]) are reimbursable only when billed in conjunction with one of the following ICD-9-CM diagnosis codes:

072.0	192.8	236.0 – 236.6	626.0 – 626.9
147.0	194.0 – 194.9	237.0 – 239.7	627.0 – 627.9
170.0	213.0	240.0 – 279.9	628.0 – 628.1
174.0 – 175.9	215.0	303.9	752.0 – 752.9
183.0 – 183.9	220	307.1	758.0 – 759.9
185	222.0	359.0 – 359.9	
186.0 – 186.6	225.0 – 225.9	456.4	
191.0	227.0 – 227.9	606.0 – 606.9	

Codes 83001 and 83002 should only be ordered when medically indicated, based on patient evaluation. Gonadotropin level tests for screening or non-indicated disease processes are not medically justified, and therefore, not reimbursable.

ICD-9-CM codes 403.0 – 403.9, 404.0 – 404.9 and 571.0 – 571.9, that were previously supported in connection with codes 83001 and 83002, have been deleted.

*This information is reflected on manual replacement page path chem 5 (Part 2).*

### Epikeratoplasty Is Non-Benefit

Effective for dates of service on or after August 1, 2007, epikeratoplasty (CPT-4 code 65767) is a Medi-Cal non-benefit.

*This information is reflected on manual replacement pages medi non cpt 1 (Part 2), surg bil mod 7 (Part 2) and tar and non cd6 4 (Part 2).*

### Urethral Dilation Billing Policy Update

Effective for dates of service on or after August 1, 2007, when billing for urethral dilation procedures with CPT-4 codes 53600 – 53621 in conjunction with cystourethroscopy procedure codes 52000 – 52334, 52341 – 52346 and 52351 – 52355 for a male recipient, a report documenting involvement of significant time and effort to perform the urethral dilation must be submitted with the claim.

*This information is reflected on manual replacement page surg urin 5 (Part 2).*

### Gemcitabine Code Conversion

Effective for dates of service on or after August 1, 2007, local code X7630 (gemcitabine, 200 mg) will be converted to HCPCS code J9201 (gemcitabine, 200 mg), in accordance with national coding requirements.

*This information is reflected on manual replacement pages chemo 11 (Part 2) and inject list 8 (Part 2).*

**Vaccine Billing Clarification**

Providers are reminded to bill CPT-4 code 90471 (immunization administration; one vaccine) to Medi-Cal to be reimbursed for the administration of vaccines that are free to the provider through a source other than the Vaccines For Children (VFC) program.

When billing code 90471, providers must indicate the vaccine administered and its source in the *Reserved for Local Use* field (Box 19) of the claim. Code 90471 may not be billed in conjunction with other vaccine injection codes (90281 – 90749 and X5300 – X7699) administered by the same provider, for the same recipient and date of service.

*This information is reflected on manual replacement pages inject 1 and 2 (Part 2) and vaccine 1 and 4 (Part 2).*

**Provider Limitation Lifted for Transesophageal Echocardiography (TEE) Codes**

Effective for dates of service on or after August 1, 2007, Transesophageal Echocardiography (TEE) CPT-4 codes 93312, 93315 and 93318 are reimbursable when billed by any provider on the same day. Subsequent claims must have the same procedure code and appropriate modifier, or they will be denied.

Providers are reminded that current policy allows only one of the three codes to be reimbursed on the same day.

*This information is reflected on manual replacement page cardio 8 (Part 2).*

**New Public Health Department Oversees Children's Treatment Program**

Effective July 1, 2007, the Children's Treatment Program (CTP) is no longer organized under the California Department of Health Services (CDHS) and has the following new address:

California Department of Public Health  
1616 Capitol Avenue, Suite 74-317  
MS 5203  
P.O. Box 997377  
Sacramento, CA 95899-7377

The address change is part of a CDHS reorganization. CDHS is split into the following separate departments:

- California Department of Public Health (CDPH)
- California Department of Health Care Services (CDHCS)

CTP is under control of the public health (CDPH) department. Claim submission and processing procedures for CTP remain the same.

Information about the CDHS reorganization is available on the Web at [www.dhs.ca.gov/home/organization/reorganization](http://www.dhs.ca.gov/home/organization/reorganization).

*This information is reflected on manual replacement pages prog 5 (Part 1) and children 1 thru 3 (Part 2).*

**New DUR Educational Articles Area on Medi-Cal Web Site**

Drug Use Review (DUR) educational articles are now available in a new location on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)). The new "DUR Educational Articles" area provides easier access to current and previously published educational articles, with titles and publication dates for each article listed and a brief description of the article. Providers can view the new DUR articles area by clicking the "DUR" link under "Provider Resources," then "DUR Educational Articles."



## Family PACT Program To Release New Provider Manual

The Family PACT (Planning, Access, Care and Treatment) Program will release its new provider manual in October 2007. This new manual will replace the current *Policies, Procedures and Billing Instructions* (PPBI) manual. Providers are asked to use the new manual once it is received.

### New Manual Features

The new Family PACT Program provider manual will contain several new features that will help ensure its overall quality and usefulness. These features will include:

- A user-friendly format and style similar to that currently found in the Medi-Cal provider manuals
- Unique section titles with locator keys to quickly identify sections of interest
- An online version for providers to access and view

### Subscription Process – Enrolled and Non-Enrolled Providers

All enrolled Family PACT Program providers will automatically receive an initial copy of the new Family PACT Program provider manual at no charge. Non-enrolled providers (subscribers) must complete a *Subscriber Order Form* and will be charged for a copy of the new provider manual. The *Subscriber Order Form* will be available in a future *Medi-Cal Update*.

Additional provider manual orders will be available for a nominal subscription charge for Family PACT providers and subscribers who would like more than one provider manual.

Annual subscriptions include monthly bulletin updates, manual replacement pages and other program-related special mailings. Monthly updates ensure that providers have access to the most current program policies and procedures.

Family PACT providers will continue to receive monthly bulletin updates, manual replacement pages and other program-related special mailings as long as they remain active providers. Family PACT providers who subscribe to receive additional manuals will have their subscriptions renewed, at no charge, upon the provider's submission of an annual renewal notice. Non-enrolled providers who subscribe, such as pharmacies and laboratories, will be charged for annual subscription renewals.

### Contact Information

For more information regarding the Family PACT Program, please call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at [www.familypact.org](http://www.familypact.org).

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*

### Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. Dates for upcoming sessions are listed below. Registration begins at 8:00 a.m., with Session I beginning promptly at 8:30 a.m.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and client eligibility enrollment supervisors, are encouraged to attend, but are not eligible to receive a *Certificate of Attendance*. Enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. The new session format offers the option for currently enrolled providers and staff to attend only the afternoon update session along with the clinical session or the billing and coding session.

Please see **Provider Orientation**, page 9



Provider Orientation (*continued*)

**Session I – Overview of the Family PACT Program:** 8:30 a.m. to 12:30 p.m. Attendance at this presentation is mandatory for clinician providers wishing to enroll in Family PACT and is recommended for other staff who are new to the program or need a refresher.

The afternoon sessions run concurrently from 1:30 p.m. to 4:00 p.m. and start with an update from the Office of Family Planning – *What's New in Family PACT* from 1:30 p.m. to 2:00 p.m.

**Session II – Clinical Practice Alerts:** 2:00 p.m. to 4:00 p.m. Clinicians in attendance who wish to become a Family PACT provider must also attend this session. Free continuing education (CE) credit is available for Session II. Please bring your medical license number with you if requesting CE credit; a continuing education request form will be available during onsite registration. Other interested clinical staff are welcome to attend and may request free CE credit for this session.

**Session III – Billing and Coding Basics Roundtable:** 2:00 p.m. to 4:00 p.m. Administrators and billers interested in Family PACT billing information may attend.

Please note the upcoming Provider Orientation and Update Sessions below.

<i>Pasadena</i>	<i>Chico</i>	<i>San Diego</i>
<b>August 14, 2007</b>	<b>October 11, 2007</b>	<b>November 1, 2007</b>
<b>8:30 a.m. – 4:00 p.m.</b>	<b>8:30 a.m. – 4:00 p.m.</b>	<b>8:30 a.m. – 4:00 p.m.</b>
Hilton Pasadena	Oxford Suites	Holiday Inn on the Bay
168 S. Los Robles Avenue	2035 Business Lane	1355 N. Harbor Drive
Pasadena, CA 91101	Chico, CA 95928	San Diego, CA 92101
(626) 577-1000	(530) 899-9090	(619) 232-3861

For a map and directions to these locations, go to the Family PACT Web site ([www.familypact.org](http://www.familypact.org)) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the appropriate location.

**Registration**

To register for an orientation and update session, go to the Family PACT Web site ([www.familypact.org](http://www.familypact.org)) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the “Registration” link next to the appropriate date and location and print a copy of the registration form. Please identify the session(s) you plan to attend.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

**Check-In**

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:00 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

**Note:** Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Please see **Provider Orientation**, page 10

## Provider Orientation (continued)

**Certificate of Attendance**

Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

**Contact Information**

For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at [www.familypact.org](http://www.familypact.org).

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*

**CCS Service Code Groupings (SCGs) Update**

Effective for dates of service on or after August 1, 2007, a number of codes are end-dated and added to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 04, 05, 06, 07, 10 and 12.

**Reminder:** SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

*The updated information is reflected on manual replacement pages cal child ser 1, 3 thru 16, 18 thru 20 and 22 thru 25 (Part 2).*

**Medi-Cal List of Contract Drugs**

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs*.

**Addition, effective July 1, 2007**

<b>Drug</b>	<b>Size and/or Strength</b>
EXENATIDE	
Pre-filled Injectable Pen	250 mcg/cc * 1.2 cc
* Restricted to use as combination therapy in the treatment of Type 2 Diabetes in individuals with an HgbA1c > 7. Must currently be on or have failed a sulfonylurea, metformin and a thiazolidinedione with a maximum quantity restriction for the 5 mcg strength of 1.2 cc per dispensing and two dispensings in a 60-day period with a duration of therapy not lasting more than 60 days.	
	250 mcg/cc * 2.4 cc
* Restricted to use as combination therapy in the treatment of Type 2 Diabetes in individuals with an HgbA1c > 7. Must currently be on or have failed a sulfonylurea, metformin and a thiazolidinedione with a maximum quantity restriction for the 10 mcg strength of 2.4 cc per dispensing with a maximum of four dispensings in a 100-day period.	

*Please see Contract Drugs, page 11*

## Contract Drugs (continued)

Changes, effective July 1, 2007

<u>Drug</u>	<u>Size and/or Strength</u>
* AMLODIPINE BESYLATE/BENAZEPRIL HYDROCHLORIDE	
* <b><u>Restricted to NDC labeler code 00078 (Novartis Pharmaceuticals Corporation) only.</u></b>	
+ Capsules	2.5 mg – 10 mg 5 mg – 10 mg 5 mg – 20 mg 10 mg – 20 mg 5 mg – 40 mg 10 mg – 40 mg
APREPITANT	
* + Capsules	80 mg 125 mg 1 x 125 mg 2 x 80 mg
* Restricted to use in cancer patients and to a maximum of either 1) one tri-fold pack per dispensing, or 2) one 125 mg capsule and/or two 80 mg capsules per dispensing.	
* <b><u>+ Capsules</u></b>	<b><u>40 mg</u></b>
* <b><u>Restricted to use for the prevention of postoperative nausea and vomiting and limited to a maximum of one capsule per dispensing, not to exceed one dispensing in any 30-day period.</u></b>	
LEVETIRACETAM	
Solution, oral	100 mg/cc
Tablets	250 mg 500 mg 750 mg <b><u>1000 mg</u></b>
OLOPATADINE HCL	
Ophthalmic solution	0.1 % <b><u>0.2 %</u></b>

+ Frequency of billing requirement

**General Medicine Bulletin 397**

Remove and replace: *Contents for GM Billing and Policy* iii thru vi \*  
blood 1/2 \*  
blood cms 1 thru 4 \*

Remove: cal child ser 1 thru 27  
Insert: cal child ser 1 thru 26

Remove and replace: can detect 1 thru 4 \*

Remove: can detect 11 thru 22  
Insert: can detect 11 thru 23 \*

Remove and replace: cardio 7/8  
chemo 11/12, 29/30 \*  
children 1 thru 4  
cif co 7 thru 11 \*  
cif sp 1 thru 10 \*  
cms comp 1/2 \*  
eval 17/18 \*  
hcpcs ii 1 thru 5 \*  
hyst 1 thru 4 \*  
inject 1/2, 5/6 \*, 21 thru 24, 41 thru 44 \*

Remove: inject 59 thru 60  
Insert: inject 59 thru 61 \*

Remove: inject drugs 1/2 \*  
Remove and replace: inject list 1/2 \*, 3/4, 5/6 \*, 7/8, 9 thru 18 \*  
inject vacc 1 \*  
medi non cpt 1  
medi non hcp 1/2 \*

Insert new section after  
the *Modifiers Used*  
*With Procedure*

Codes section: non inject 1/2 \* (new)

Remove and replace: non ph 5/6 \*  
once 1 thru 4 \*

Remove: ophthal 1 thru 6  
Insert: ophthal 1 thru 7 \*

Remove and replace: path chem 5/6  
path surg 3/4 \*  
radi 1 thru 7 \*  
radi dia 15/16 \*, 19/20 \*, 23 thru 28 \*  
radi dia ult 1/2 \*

\* Pages updated due to ongoing provider manual revisions.

**Part 2** (continued)

Remove and replace:

- rates max 5/6 \*
- respir 5 thru 8 \*
- sub acut adu 3/4 \*
- surg 3/4 \*
- surg bil mod 7/8
- surg cardio 3/4 \*, 7/8 \*
- surg integ 3/4 \*
- surg muscu 5/6 \*
- surg nerv 5/6 \*
- surg urin 3/4 \*, 5
- tar and non cd1 3 thru 5 \*
- tar and non cd2 3 thru 6 \*
- tar and non cd3 3/4 \*
- tar and non cd4 3 thru 7 \*
- tar and non cd5 1 thru 6 \*
- tar and non cd6 1/2 \*, 3/4, 5/6 \*
- tar and non cd7 1 thru 3 \*
- tar and non cd9 1 thru 7 \*
- tar field 1 thru 11
- vaccine 1 thru 4

\* Pages updated due to ongoing provider manual revisions.